Flu Vaccine Consent Form

HEALTH HERO FLORIDA
You Keep Them Learning. We Keep Them Healthy

School Name: _____ **Clinic Date:** _____

PLEASE COMPLETE ALL OF THE INFORMATION BELOW - **Please print using ink** (Incomplete forms will not be accepted)

FIRST NAME of student:	**MIDDLE INITIAL**	**LAST NAME of student:**	**SUFFIX (Jr., III, etc)**
Gender: Male Female	**Birthdate: (mo,day,yr)**	**Age**	**Homeroom Teacher/Grade**
Address		**Phone # ( ) -**	**Mother's Maiden Name:** (For registry)
City	**Zip Code**	**State**	**Race:** (Circle one) African American / Black White Alaskan/ Native-American Asian Hawaiian / Pacific Islander Other **Ethnicity:** (circle one) Hispanic Non-Hispanic
Email address:			

The current health care laws require us to bill your insurance company for the vaccine. The service is offered at no cost to you. Answers are always confidential.

Please fill out the following questions pertaining to your health insurance:

Medicaid ☐ **No insurance** ☐	**Insurance Company:**
Policy Holder's First Name:	**Policy Holder's Last Name:**
Member ID:	**Policy Holder's Date of Birth: (mo,day,yr)**

CHECK YES OR NO FOR **EACH** QUESTION

YES	NO	
☐	☐	1. Has your child ever had a life-threatening reaction(s) to the flu vaccine in the past?
☐	☐	2. Has your child ever had Guillain-Barre' syndrome?
☐	☐	3. Does your child have an allergy to eggs?
☐	☐	4. Does your child have a blood disorder such as hemophilia?
☐	☐	5. Will this be the first time your child has ever received a flu vaccination?

I have read the information about the vaccine and special precautions on the Vaccine Information Sheet. I am aware that I can locate the most current Vaccine Information Statement and other information at www.immunize.org or www.cdc.gov. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent for the vaccine to be given to the person listed above of whom I am the parent or legal guardian and having legal authority to make medical decisions on their behalf. I acknowledge no guarantees have been made concerning the vaccine's success. I hereby release MaxVax LLC., affiliates, affiliated schools of nursing, their directors, employees and agents from any and all liability arising from any accident or act of omission which arises during vaccination. I understand this consent is valid for 6 months and that I will make the school aware of any health changes prior to the vaccination clinic date. I acknowledge that I am giving permission for MaxVax LLC. to adjudicate and appeal claims with my insurance providers on my behalf. Clinic dates can be obtained from the school. I understand that the health-related information on this form will be used for insurance billing purposes and your Personal Health Information contended herein will be protected. I request and voluntarily consent for the vaccine to be given and recorded in Florida SHOTS for the person listed above.

Printed Name of Parent/Guardian	Signature of Parent/Guardian	Relationship to child	Date

VIS CDC IIV 08/15/2019 FLUCELVAX
LOT Number: **EXP Date:**
RN #_____ Date:_____
AREA FOR OFFICIAL ADMINSTRATION USE ONLY

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